Gallagher | STUDENT HEALTH & SPECIAL RISK

Cornell University

Extension of Coverage

Student Health Plan (SHP) Enrollment Form

STUDENT INFORMATION

Student Name________________________ Date of Birth____/____/_____ Gender ______________
first name, middle initial, last name *mm / dd / yyyy*

7-digit Cornell ID#______________ Cornell Net ID______________ Current Phone #______-______-______

Class Level (check one): ❐ Undergraduate ❐ Professional ❐ Graduate

Reason for extension request (Extension is contingent on validation of change in student eligibility):

❐ Graduating		❐ Leave of Absence	❐ Other
❐ Fall ❐ 3-month extension	❐ Spring or August ☑ 3-month extension	❐ 3-month extension (beginning April 1 – end of plan year) ❐ 6-month extension (through end of plan year)	☑ 3-month extension

ENROLLMENT DEADLINE: 60 days after change in student eligibility per Certificate of Coverage

Check all boxes that apply

❐ **Extend my enrollment in the Student Health Plan** ❐ **Extend my dependent(s) in the Student Health Plan**

PREMIUMS AND COVERAGE PERIOD

	Quantity	# months (3 or 6)	Effective Date	Termination Date	Total Charge = (Quantity * months * $285)
Student	1				$
Dependendent(s)					$
TOTAL CHARGE					$

PAYMENT INSTRUCTIONS: **All extensions must have proof of payment to be processed.**
Please go to: https://shpdirectpay.securepayments.cardpointe.com/ to pay for your coverage extension.
A copy of your payment receipt should be submitted with this application.

❐ I acknowledge that I am responsible for paying the premium for the extension of coverage for myself (and my dependents if applicable) within 60 days of my eligibility change. My failure to pay the premium within 60 days of the start of my extension will result in termination of my extension of coverage for myself and my dependents, and I will be billed by the provider for any charges incurred after my eligibility change.

SIGNATURES

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Student signature____ Date____/____/_____

PLEASE COMPLETE AND SUBMIT THIS FORM AND YOUR PROOF OF PAYMENT RECEIPT TO GALLAGHER STUDENT HEALTH VIA EMAIL: Quincy.BSD.enrollmentteam@AJG.com